MEDDIC-MS Data Book

Medicaid Encounter Data Driven Improvement Core Measure Set
Quality Assessment and Performance Improvement

Vol. 1--2005 Overall Performance Data
Wisconsin Family Medicaid and BadgerCare

Wisconsin Department of Health and Family Services
Division of Health Care Financing, Bureau of Managed Health Care Programs

September 2006

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Introduction and Background

MEDDIC-MS (Medicaid Encounter Data Driven Improvement Core Measure Set) is Wisconsin's set of automated, standardized performance measures for Family Medicaid and BadgerCare (the State Children's Health Insurance Program, SCHIP) managed care.

Use of MEDDIC-MS was approved by the Centers for Medicare and Medicaid Services (CMS) as part of its review of the state's quality improvement strategy in August 2003. The Agency for Healthcare Research and Quality (AHRQ) has recognized MEDDIC-MS for inclusion in the National Quality Measures Clearinghouse (NQMC®). To view the measure summaries on the NQMC, go to: http://www.qualitymeasures.ahrq.gov/browse/measureindex.aspx and scroll down to "State of Wisconsin."

MEDDIC-MS and MEDDIC-MS SSI performance measures have been approved for health plan accreditation by URAC® (Utilization Review Accreditation Commission).

MEDDIC-MS uses monthly HMO encounter data and other electronic data sources, to operate without paper medical record review. This improves patient privacy protection, reduces costs and improves measure accuracy. Medical record review is used for data validity audits, ambulatory quality of care audits, when HMOs wish to augment their encounter data and for special audit functions.

Results on each measure are calculated by a third party, not by HMOs or the DHFS itself, improving consistency and accuracy.

To drive performance improvement, an integral goal-setting system applies to some measures.

Performance reports for prior years are available on the Wisconsin Medicaid Managed Care Website. To view these reports, please go to: http://www.dhfs.state.wi.us/medicaid7/providers/index.htm and scroll down to "Quality Reports."

The data in this booklet presents program-wide performance rates for all HMOs combined on all MEDDIC-MS performance measures based on calendar year 2005 data, as well as trend data based on past performance.

Technical specifications for the MEDDIC-MS measures are available upon request. Contact: Gary R. Ilminen, RN at (608) 261-7839 or ILMINGR@DHFS.STATE.WI.US.

New Enrollee Health Needs Assessment (NEHNA) survey

DHFS has implemented a proactive approach to performance improvement called the New Enrollee Health Needs Assessment (NEHNA) survey. The NEHNA survey is administered by the state's enrollment broker at the time of enrollment. Enrollee-specific health care needs, including special health care needs such as those for chronic conditions, are identified in a voluntary telephone survey. Information about those needs is shared with the enrollee's HMO. In this way, the Department facilitates quality improvement by informing HMOs of the health care needs of new enrollees, even before the enrollee may have a visit with their doctor.

Care Analysis Projects

DHFS has implemented a care management support system called Care Analysis Projects (CAP). Through CAP, enrollee-specific health care needs are identified from encounter data and those needs are shared with the enrollee's HMO. CAP allows the Department to assist HMO outreach to individuals with special health care needs.

CAP focuses on several chronic conditions and on the provision of key preventive services. Chronic conditions included are congestive heart failure, asthma, and diabetes. Preventive health services include lead screening and prenatal risk assessment.

MEDDIC-MS and CAP work together. CAP provides data-driven targeted intervention and MEDDIC-MS provides performance assessment.

HMO Performance Improvement Projects

The Wisconsin Medicaid/BadgerCare HMO contract requires HMOs to complete at least two performance improvement project reports annually. These projects drive quality improvement.

To view a summary of HMO Performance Improvement Project topics, go to:
HTTP://WWW.DHFS.STATE.WI.US/MEDICAID7/REPORTS_DATA/MCORGPERIMP.HTM

Other volumes in the MEDDIC-MS 2004 Data Book include:

MEDDIC-MS 2005 Data Book, Volume 2, HMO-specific Performance Data, Wisconsin Family Medicaid and BadgerCare.

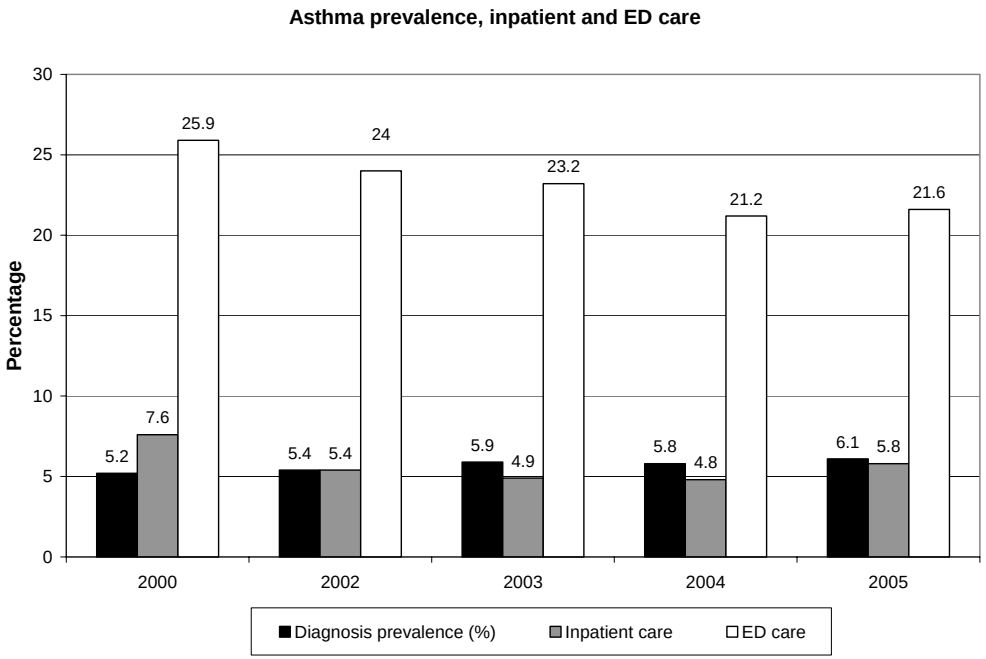
Results on Clinical Performance Measures

Asthma care

Monitoring measure

Data points—

- Asthma prevalence increased since 2000.
- Utilization of both emergency department care and inpatient care has declined between 2000 and 2005.
- Emergency care for asthma decreased from 25.9 percent in 2000 to 21.6 percent in 2005, though a slight increase occurred from 2004.
- Inpatient care for asthma declined from 7.6 percent in 2000 to 5.8 percent in 2005, but a slight increase occurred between 2004 and 2005.



Asthma is a chronic disease of the lungs. Asthma causes episodes where airflow in and out of the lungs is reduced by constriction of the airways and by excess mucous.

Asthma can be managed with appropriate medications and patient education. According to a large study[1] published in May 2006, 34 percent of asthmatics without insurance coverage used urgent or hospital emergency department care for severe asthma symptoms—more than 12 percent higher than enrollees in Wisconsin Medicaid/BadgerCare HMOs.

HMO disease management programs for asthma may have been an important factor in the improvement; nine Medicaid/BadgerCare HMOs offer asthma disease management. In addition, eight HMOs have conducted performance improvement projects on asthma care since 2000. Also, the DHFS has operated a Care Analysis Project on asthma since 2001 and it is an item on the New Enrollee Health Needs Assessment (NEHNA) survey.

[1] *"Lack of insurance and urgent care for asthma—a retrospective cohort study,"* BMC Public Health. 2006;6 ©2006 Markovitz et al.

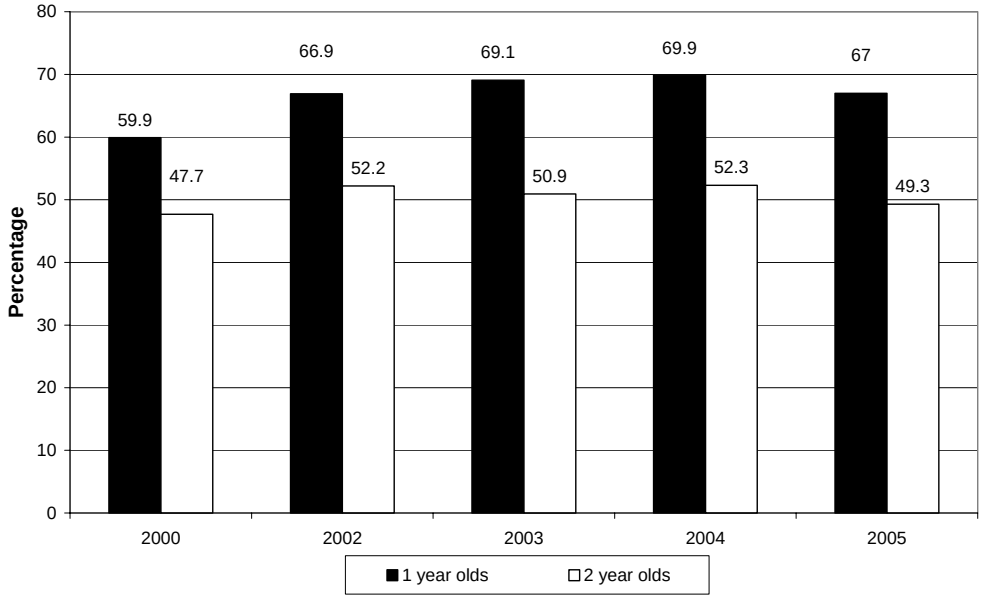
Blood lead toxicity screening

Targeted performance improvement measure

Data points—

- The screening rate for one-year-old children has increased from 59.9 percent in 2000 to 67 percent in 2005.
- The screening rate for two-year-old children increased from 47.7 percent in 2000 to 49.3 percent in 2005.
- A small decline in performance rates occurred since 2004.
- Since 2000, 5 HMOs have conducted performance improvement projects on lead screening, four of those were conducted since 2002.

Blood lead toxicity screening, one and two-year olds



Children in Medicaid are at risk for exposure to lead in their living environment. Screening for blood lead toxicity is required for children at age one and two years and up to age six if elevated blood lead levels or risk factors are present.

In 2001, the Department implemented a Care Analysis Project (CAP) on blood lead toxicity screening. Recipient-specific lead testing data is shared with the individual's HMO in an effort to assist HMOs with identification of children in need of lead screening. This facilitates outreach and follow-up for children who have not received screening. This on-going effort may be a factor in the improvement in the lead screening rate trends.

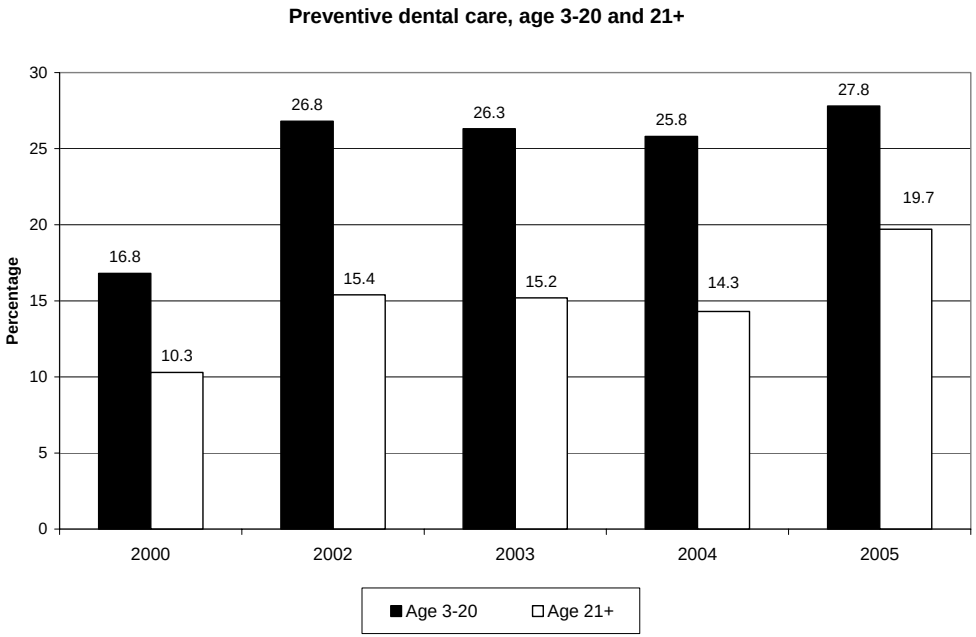
HMO performance improvement goal-setting applies to this measure.

Dental (preventive) services

Targeted performance improvement measure

Data points—

- The preventive dental services rate for children has increased 11 percentage points since 2000.
- The rate for adults has increased 9.4 percentage points.
- Though improvement has occurred since 2000, additional performance improvement strategies are being implemented.
- In 2005, four dental service codes were added to the measure and one was deleted.



Preventive dental services include initial and comprehensive dental examinations, prophylaxis, topical application of fluoride and application of sealants.

Dental care soon after the eruption of teeth can prevent development of dental caries, tooth loss, oral infections, abscesses and other problems. Teeth generally first erupt between age 6 and 28 months and emerge enough to benefit from preventive care between 1 and 3 years.

In 2005, four HMOs in the Milwaukee area offered dental services. HMO enrollees in the rest of the state receive dental benefits on a fee-for-service basis HMO.

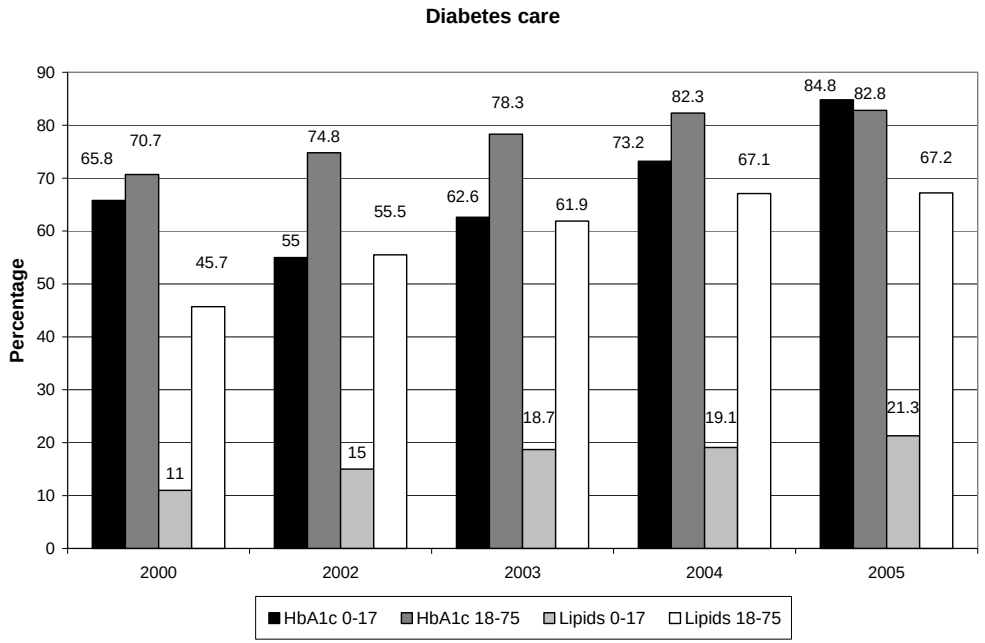
Despite apparent initial improvement in access indicated by higher utilization for both age groups, the overall percentage of enrollees receiving preventive dental services remains relatively low. Improving delivery of dental care remains a performance improvement opportunity.

Diabetes care

Targeted performance improvement measure

Data points—

- Performance improved on all indicators for all ages.
- Lipid test rates for 18-75 year olds increased from 45.7 percent in 2000 to 67.2 percent in 2005.
- The HbA1c test rates for 18-75 year olds increased from 70.7 percent in 2000 to 82.8 percent in 2005.
- The HbA1c rate for 0-17 years of age increased from 65.8 percent in 2000 to 84.8 percent in 2005.
- The rate for lipid testing for 0-17 years of age has also improved, increasing from 11 percent in 2000 to 21.3 percent in 2005.



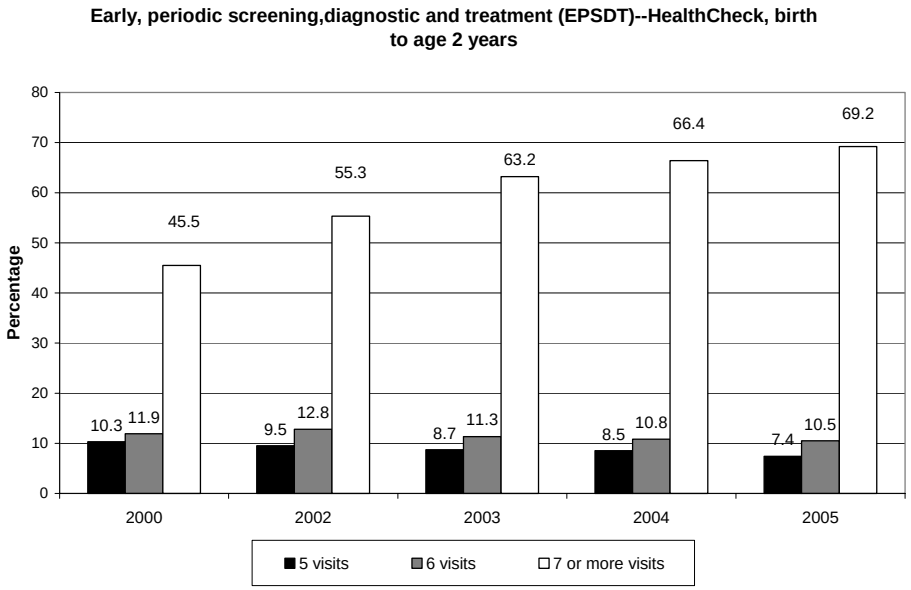
Diabetes mellitus is a chronic condition that can affect the heart, kidneys and eyes. But, with proper care, serious problems can be reduced or prevented. Two blood tests are important for effective diabetes care.

One is the hemoglobin A1c (HbA1c), a blood test that indicates the level of blood sugar control over time. The other test is the lipid profile, a blood test that monitors the levels of "fats" (lipids) in the blood stream.

These tests allow assessment of key indicators for diabetic management. The chart reflects the percentage of HMO enrollees diagnosed with diabetes who received the tests. The percentages are reported for two age groups: birth (0) to age 17 years and 18 to 75 years of age.

Seven HMOs have conducted performance improvement projects on diabetes care since 2000 and 11 HMOs have disease management programs for diabetes. It is an item on the New Enrollee Health Needs Assessment (NEHNA) survey and it has been a Care Analysis Project topic since 2001. DHFS performance improvement goal-setting applies to this measure.

EPSDT (HealthCheck) comprehensive well-child exams *Monitoring Measure*



Data points—

- The rate for children receiving 7 or more HealthCheck exams by age two years has increased from 45.5 percent in 2000 to 69.2 percent in 2005.
- The rates for children in each age cohort between age 3 and 20 years of age receiving at least 1 visit in the look-back period have also shown sustained, if more gradual improvement since 2002.
- Ten HMOs have conducted performance improvement projects on HealthCheck since 2000.

Early, Periodic Screening, Diagnosis and Treatment (EPSDT) services are federally required for children in Medicaid. Wisconsin calls EPSDT services HealthCheck screens.

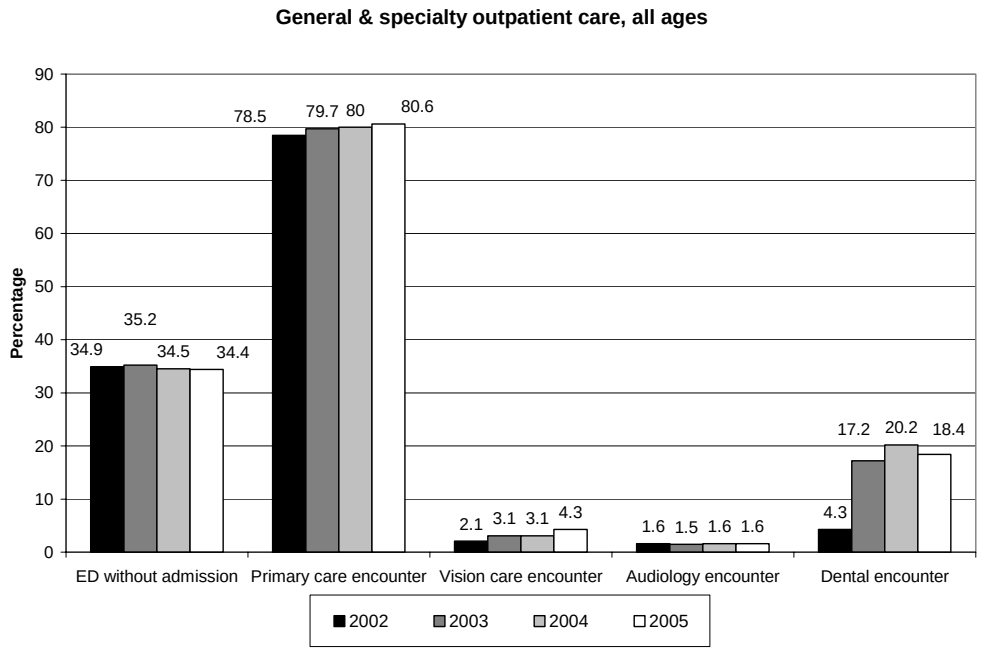
HealthChecks include an unclothed physical exam, age appropriate immunizations, lab work, including blood lead toxicity tests, health and developmental history, vision and hearing assessment and oral assessment beginning at age 3.

Data for age group 3-20 years was not calculated in 2000-01.

General and specialty care-outpatient *Monitoring measure*

Data points—

- One in three of all HMO enrollees had at least one emergency department (ED) care encounter that did not result in subsequent hospitalization.
- About 8 out of every 10 HMO enrollees have at least one primary care encounter per year.
- Access to vision and hearing services remained stable.
- Access to general dental services has increased from 2002 to 2005, but additional strategies for improvement will be implemented.



This measure assesses access to emergency care that does not result in subsequent hospitalization, access to primary care, vision care, audiology services and dental care. Access to these outpatient or ambulatory care services is essential for overall health maintenance and improvement.

The measure tracks what percentage of Medicaid and BadgerCare HMO enrollees had access to those services on at least one occasion during the look-back period; some enrollees had multiple such encounters.

Four HMOs provide dental care under their contract with the Department. General dental services include interventions such as fillings, extractions and so on, as well as all preventive services. See also "Dental (preventive) care" on page 10 for further information on other dental care services.

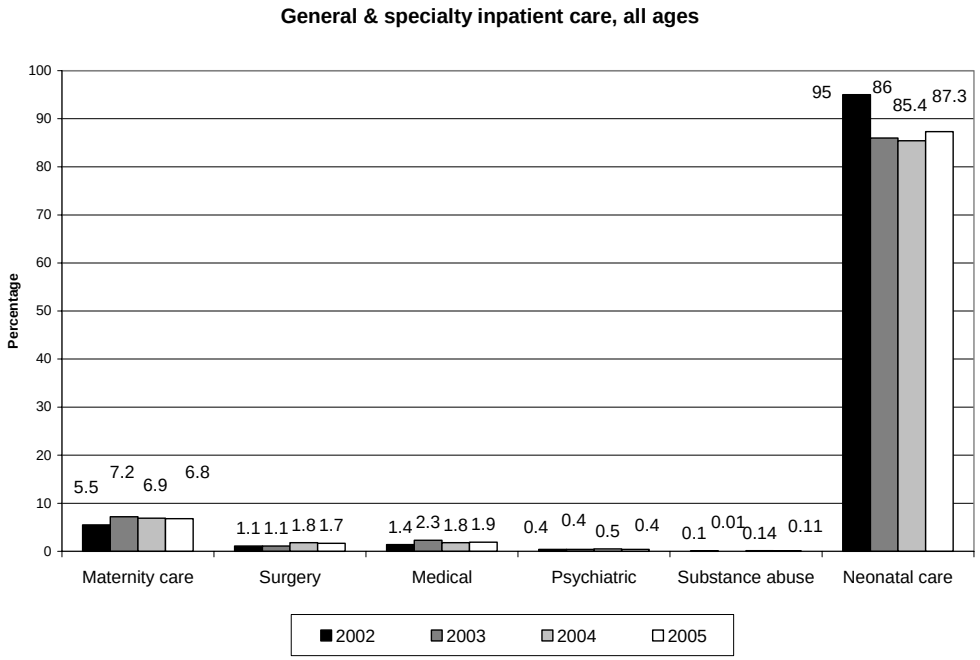
The need for vision, audiology and other special outpatient care services are an item on the New Enrollee Health Needs Assessment (NEHNA) survey.

General and specialty care-inpatient

Monitoring measure

Data points—

- Maternity, surgical, medical, psychiatric and substance abuse care rates have remained about the same from 2002 to 2005.
- Neonatal care has remained above 85 percent from 2003 to 2005.



Some conditions may require hospital or *inpatient* care.

General categories of care monitored include maternity, surgery, medical, psychiatric, substance abuse and neonatal (newborn) care.

By itself, this measure is not an all-inclusive indicator of sufficiency of access to services, or of appropriateness of care. However, when used in conjunction with other data such as satisfaction, grievance and appeal data, outpatient care data and other measures, it provides a reasonable basis for assessment of overall service delivery.

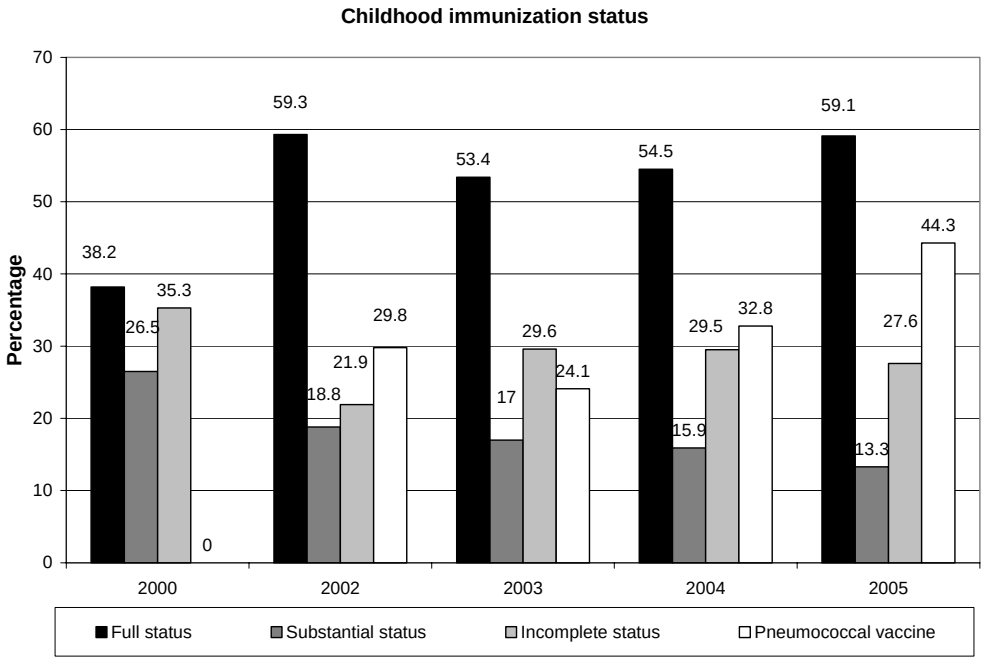
Information about enrollee inpatient care needs is an item on the New Enrollee Health Needs Assessment (NEHNA) survey.

Immunizations for children

Targeted performance improvement measure

Data points—

- The rate of full immunization status has increased 20.9 percentage points since 2000. Vaccine shortages from 2002 to 2004 have adversely affected performance in the period.
- The rate for children receiving 4 doses of pneumococcal vaccine increased 14.5 percent from 2002 to 2005.
- Vaccine shortages also affected the rate of pneumococcal vaccination in that time period and remain a factor in the delivery of some antigens.



Immunizations can protect young children from potentially serious infectious diseases. Immunization is believed to be one of the safest and most effective health care services available.

This measure assesses the percentage of children enrolled in Medicaid/BadgerCare HMOs who have achieved full immunization status, substantial immunization status and who have incomplete immunization status. The rate of administration of 4 doses of the multivalent pneumococcal vaccine is included as a monitoring measure. Substantial status refers to children who have received most but not all of the doses of certain vaccines given in multi-dose series believed necessary to confer substantial immunity.

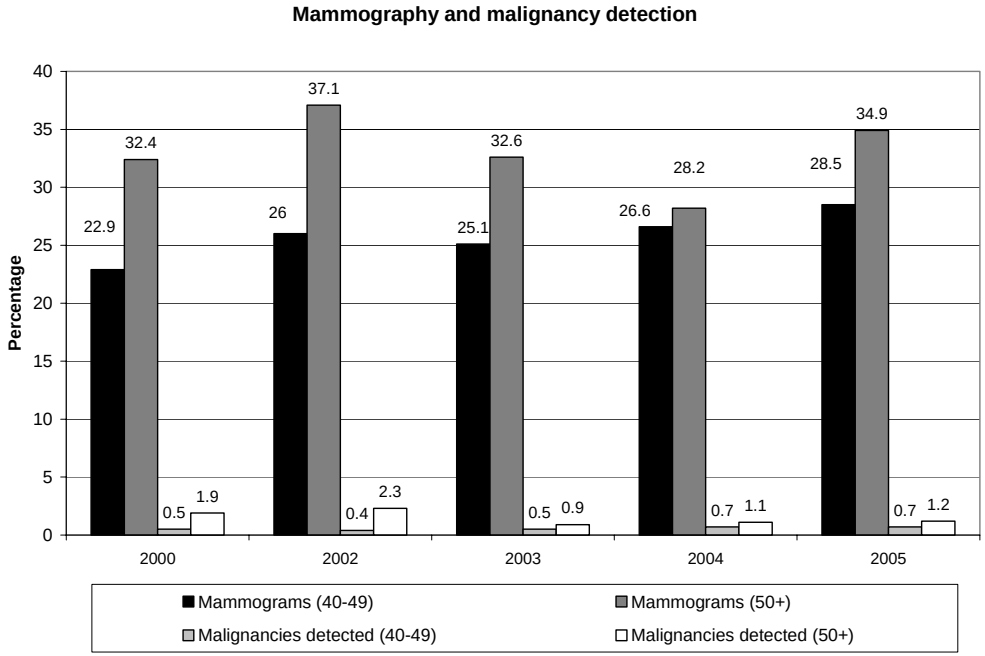
Two HMOs have made childhood immunizations the subject of performance improvement projects reported to the DHFS since 2002. DHFS performance improvement goal-setting is in effect for this measure.

Mammography (screening) and malignancy detection

Monitoring measure

Data points—

- The percentage of women screened in the 40-49 age group has increased since 2000, from 22.9 percent to 28.5 percent.
- The rate for women over age 50 has increased since 2000, from 32.4 percent to 34.9 percent.
- Detection of breast malignancies, has ranged from 0.4 percent to 0.7 percent in the 40-49 year age group since 2000. The malignancy detection rate in the 50+ age group has ranged from a high of 2.3 percent in 2002 to a low of 0.9 percent in 2003.



Screening mammography is recognized as a highly effective method for early detection of breast cancer. Early detection of breast cancer improves outcomes of treatment and long-term survival.

The American Cancer Society and the National Cancer Institute each recommend that women over age 40 have regular screening mammograms.

Only a small percentage of enrollees in Medicaid/BadgerCare are women over age 40. Nevertheless, provision of screening mammography is important because of the benefits of early detection and treatment.

This measure assesses screening mammography rates for women aged 40-49 and over age 50 years, as well as malignancy detection rates.

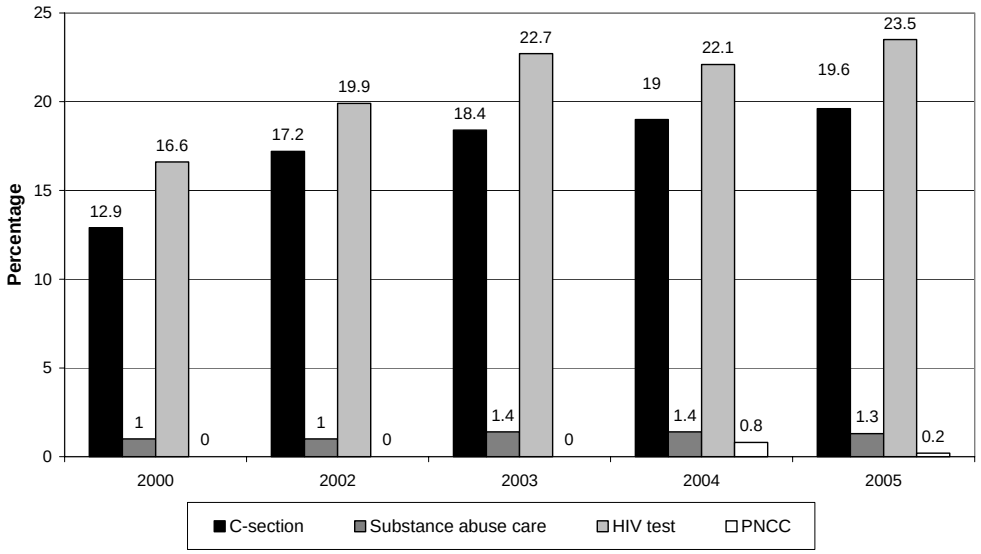
Maternity care

Monitoring measure

Data points—

- The rate of births by C-section has steadily increased from 12.9 percent in 2000 to 19.6 percent in 2005.
- Provision of substance abuse care in the perinatal period remained stable at about 1.0 percent. Provision of HIV screening increased from 16.6 percent in 2000 to 23.5 percent in 2005.
- PNCC was not calculated in 2000 and 2002. The rate has remained under one percent since 2003.

Maternity care: C-sections, perinatal substance abuse care, HIV test and PNCC



Cesarean section (C-section) childbirth may be medically necessary in certain circumstances. However, growing numbers of "elective" procedures are occurring.[2] C-section delivery rates have increased nationwide. According recent data from the Centers for Disease Control and Prevention, the national rate has increased from 20.8 percent in 1995 to 25.3 percent of all births in 2001.[3] Due to the number of women of child-bearing age in Medicaid/BadgerCare, tracking the C-section rate is important. Use of C-sections is increasing in Wisconsin.

Other health care services often provided in the perinatal period are important to the health of both mother and child. Three such services are substance abuse treatment services, voluntary HIV screening tests and prenatal care coordination (PNCC) for high-risk pregnancies.

Information about pregnancy is gathered with the New Enrollee Health Needs Assessment (NEHNA) survey.

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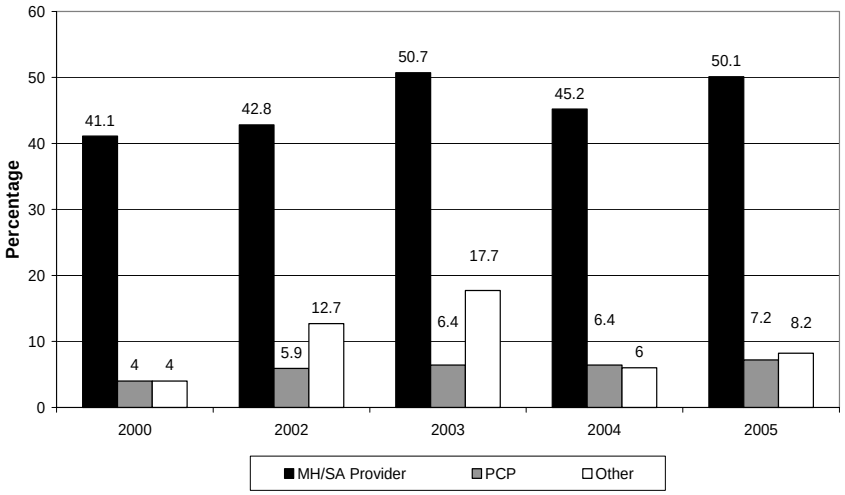
[2] *Cesarean Delivery on Maternal Request,* Evidence Report (Publication No. 06-E009), Evidence-based Practice Center: RTI-University of North Carolina, March 2006.

[3] Kozak LJ, Owings MF, Hall MJ. National Hospital Discharge Survey: 2001 annual summary with detailed diagnosis and procedure data. National Center for Health Statistics. Vital Health Stat 13(156). 2004.

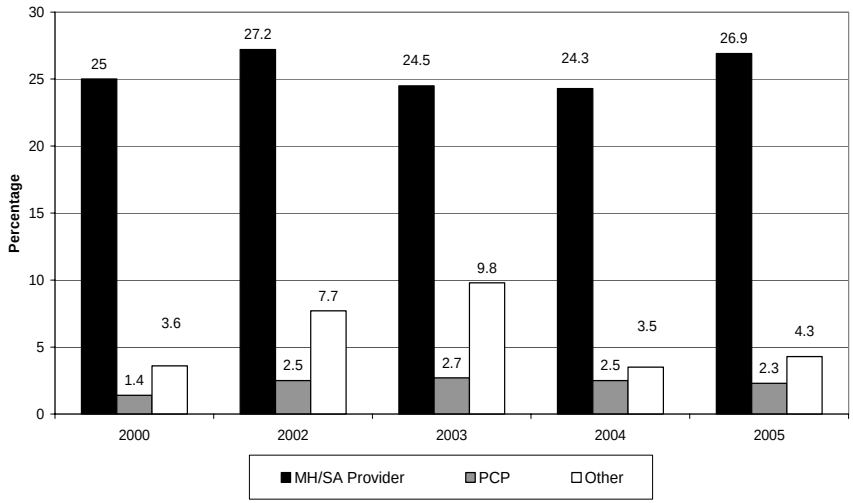
Mental health/substance abuse (MH/SA) follow-up care within 7 and 30 days of inpatient discharge

Targeted Performance Improvement Measure

Mental health/substance abuse ambulatory care within 30 days of inpatient stay, by provider type, age 6 years & up



Mental health/substance abuse ambulatory care within 7 days of inpatient stay, by provider type, age 6 years and up



Data points—

- Follow-up care by specialty providers has increased from 2000 to 2005, both within 7 days of discharge and within 30 days.
- PCPs play a smaller, but consistent role in delivering follow-up care.

Research has shown that outpatient care after inpatient care for mental illness or substance abuse is effective in reducing readmission for the same diagnosis.[4]

This measure evaluates provision of outpatient follow-up care by specialty and primary care providers (PCP) within 7 days of discharge and within 30 days of discharge from an inpatient mental health or substance abuse stay.

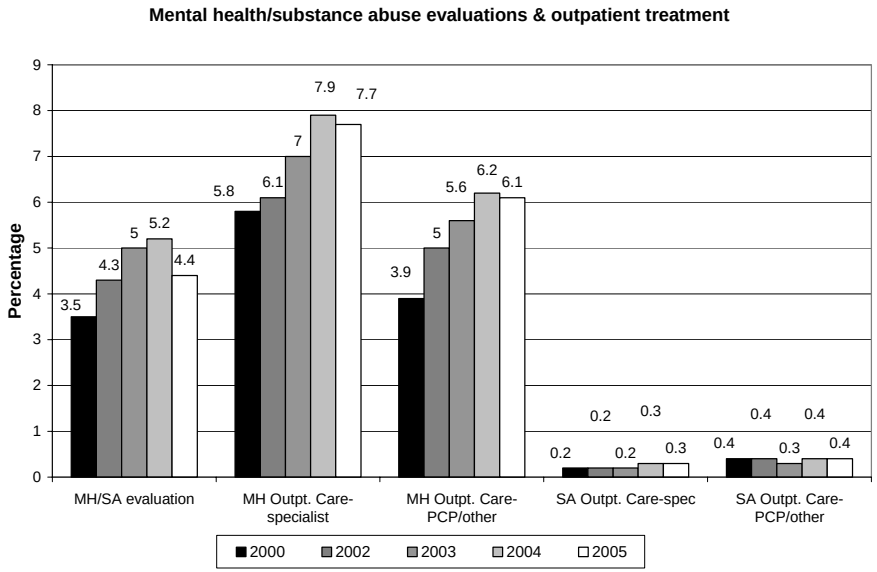
[4] *Evaluation and the Health Professions, Special Edition, State Medicaid Quality Programs*, "Outpatient Utilization Patterns and Quality Outcomes after First Acute Episode of Mental Health Hospitalization," Delmarva Foundation, December 2000.

Mental health / substance abuse-evaluations & outpatient care

Monitoring Measure

Data points—

- Access to mental health and substance abuse evaluations has increased from 3.5 percent in 2000 to 4.4 percent in 2005, though there was a small decline from 5.2 percent in 2004.
- Access to outpatient mental health care by both specialist and primary care providers increased in the period.
- Access to outpatient substance abuse care from specialist and primary care providers remained unchanged from 2000 to 2005.



Mental health and substance abuse (MH/SA) conditions can often be successfully treated on a day treatment or outpatient basis. Outpatient treatment is often preferred by enrollees over inpatient care. Thus, access to day and outpatient treatment services is both preferred by enrollees and useful to reduce the need for inpatient care.

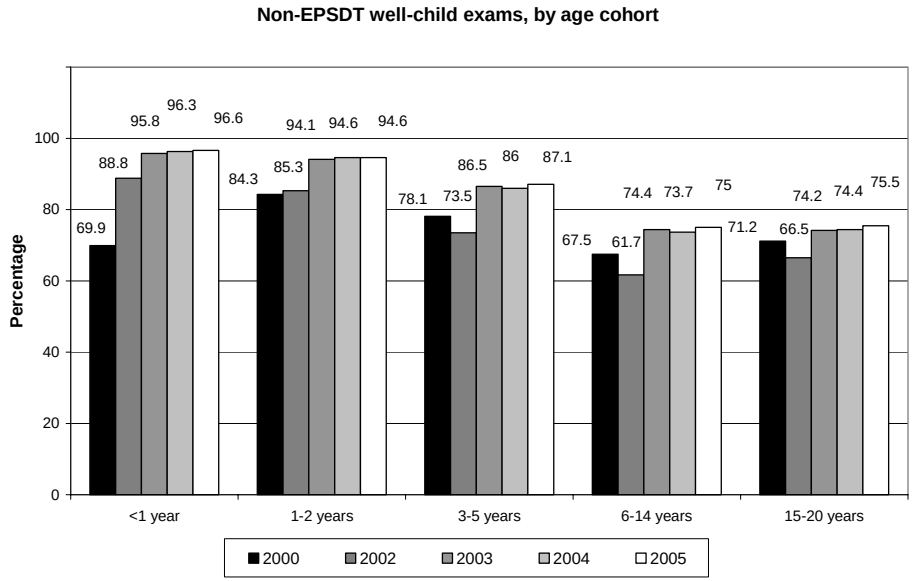
This measure tracks the provision of these services by provider type in order to gain insight into HMO network adequacy. Care by a specialist may be preferable or essential in some instances, however, primary care providers may also be able to provide services in many others.

Non-EPSDT well-child exams

Monitoring measure

Data points—

- The rate for children with at least one visit in the look-back period improved by 26.7 percentage points among children <1 year of age since 2000.
- The rate for children with at least one visit in the look-back period improved by 10.3 percentage points among children 1-2 year of age since 2000.
- Rates in all other age groups have also increased since 2000.



Non-EPSDT (non-HealthCheck) well-child visits are primary care visits that do not qualify as EPSDT or HealthCheck visits (see page 12), but do result in delivery of preventive or other primary health services.

Research[5] has shown that states with the highest rates of provision of well-child visits had the lowest rates of preventable hospitalizations for those children. Conversely, states with the lowest rates of well-child care had the highest rates of preventable hospitalizations.

The authors of the study concluded that the "association between preventive care and a reduction in avoidable hospitalizations was robust and was consistent across the states and racial and ethnic groups."

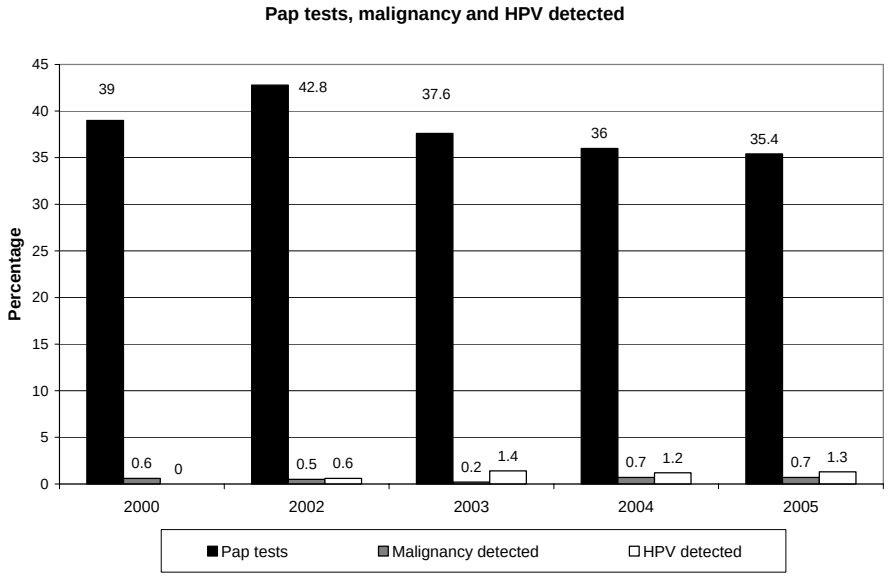
[5] *Effectiveness of compliance with pediatric preventive care guidelines among Medicaid beneficiaries*. Hakim RB, Bye BV. July 2001. PEDIATRICS, Vol. 108, No.1:90-97.

Pap tests-cervical cancer screening

Targeted Performance Improvement Measure

Data points—

- Provision of Pap tests has shown a small decline since 2000.
- Malignancy detection rates have remained about the same-under one percent.
- HPV detection rate has remained about the same since 2002 at about one percent.



According to the Centers for Disease Control (CDC), cervical cancer remains a leading preventable cause of death among women. Women of child-bearing age make up a significant number of Medicaid/BadgerCare HMO enrollees. Consequently, providing early detection tests is an important service.

Early detection is relatively easy and is the key to a high probability of survival. The most common method for early detection is called the "Pap test." The Pap test is generally performed every three years, beginning when the woman becomes sexually active or by age 18 years. Thus, the Pap test is not required annually, and the measure is designed to take this into account.

According to the CDC, Human Papillomavirus (HPV) infection is a causal factor in more than 90 percent of cervical cancers. A new vaccine for HPV has been approved by the FDA and is likely to be an important tool in prevention of cervical cancer. This measure assesses the detection rates for malignancy and HPV infection.

One HMO has conducted a performance improvement project on increasing Pap test rates since 2000. In an effort to improve performance, the DHFS has moved the Pap test indicator from Monitoring Measure status to Targeted Performance Improvement Measure status and added it to the Goal-setting program.

Analysis of performance trends, quality improvement opportunities and strategic implications

Summary of trends on selected measures from 2000 to 2005:

- ***Asthma care:*** Prevalence of asthma increased slightly, but the need for emergency department services for asthma declined from 25.9 to 21.6 percent and the need for inpatient care declined from 7.6 to 5.8 percent.
- ***Blood lead toxicity screening:*** rates improved--increasing from 59.9 to 67 percent for 1 year olds and from 47.7 percent to 49.3 percent for 2 year olds. Both rates declined slightly from 2004 to 2005.
- ***Childhood immunizations:*** rate for children with full immunization status[6] increased from 38.2 to 59.1 percent.
- ***Dental preventive care:*** rates improved for children age 3 to 20 years from 16.8 percent to 27.8 percent and improved from 10.3 to 19.7 percent for adults (age 21+).
- ***Diabetes care:*** hemoglobin A1c (HbA1c) testing rate improved from 70.7 to 82.8 percent and lipid profile testing rate improved from 45.7 to 67.2 percent for adult diabetics. HbA1c rates improved even more for children and adolescents with diabetes increasing from 65.8 percent to 84.8 percent; lipid profile rates increased from 11 percent to 21.3 percent.
- ***EPSDT (HealthCheck) well-child exams:*** rate for children age 2 years and younger receiving 7 or more exams improved from 45.5 to 69.2 percent. Rates for older children receiving at least one exam increased in each age cohort, by an average of approximately 3 percent.
- ***General & specialty outpatient care:*** The rate for ED encounters without subsequent admission remained at just over 34 percent. Primary care encounter rates edged up to just over 80 percent. Vision and audiology utilization rates remained about the same. General dental care increased from 4.3 to 18.4 percent.
- ***General & specialty inpatient care:*** Rates for inpatient services generally remained about the same.
- ***Mammography (breast cancer detection for women):*** rate increased from 22.9 to 28.5 percent for women age 40-49. For women 50+ years of age, the rate increased from32.4 to 34.9 percent. Malignancy detection remained stable during the period in each age cohort.
- ***Maternity care:*** C-section rate increased for the fourth straight year from 12.9 to 19.6 percent. Substance abuse treatment in the perinatal period remained stable at about 1 percent. Voluntary HIV testing rate increased from 16.6 to just over 23.5 percent.
- ***MH/SA follow-up care:*** Follow-up care within 7 days by specialist increased from 25 to 26.9 percent; within 30 days increased from 41.1 to 50.1 percent. Follow-up by PCPs trended up slightly.

[6] Based on Centers for Disease Control (CDC) Advisory Committee on Immunization Practices (ACIP) recommendations.

- ***MH/SA evaluations and outpatient care:*** Evaluations increased from 3.5 to 4.4 percent, though a small decline occurred from 2004 to 2005. Behavioral day treatment by specialists increased from 5.8 to 7.7 percent; by PCPs/others from 3.9 to 6.1 percent. Substance abuse outpatient care by all provider types remained stable from 2000 to 2005.
- ***Non-HealthCheck well-child exams:*** This rate increased for children birth to age 1 year from 69.9 to 96.6 percent. Rates of provision of this service increased in all other age cohorts up to age 21 years as well.
- ***Pap tests (cervical cancer detection for women):*** This rate decreased from 39 to 35.4 percent since 2000. Malignancy and HPV detection rates were stable during the period.

Sustained improvement has occurred, but progress may stall on some indicators

Performance data trended from 2000 to 2005 shows that, on a variety of measures, the quality improvement strategy to "ramp up" performance over time appears to be effective. However, performance on some indicators has been flat and on some others, performance improvement has begun to stagnate after a period of sustained improvement. Most of those instances are in areas where further improvement should be possible.

Those clinical areas where multiple strategies have been implemented appear to have the most significant improvements. Multiple strategies include HMO performance improvement projects, disease management by HMOs, data sharing and targeted outreach under the Care Analysis Projects (CAP), and early care need identification using the NEHNA (New Enrollee Health Needs Assessment) survey.

For example, emergency department and inpatient care utilization for asthma declined from 2000 to 2005, even though disease prevalence increased slightly (see page 8). Asthma is included in the DHFS Care Analysis Project (CAP) care need information is provided to HMOs through the NEHNA survey. Also, 9 HMOs have disease management for asthma and 8 HMOs have conducted performance improvement projects on the subject since 2000.

Similarly, diabetes care indicators improved between 2000 and 2005 (see page 11). Diabetes is included in the Care Analysis Project and NEHNA survey. It has been the subject of seven HMOs' performance improvement projects since 2000 and11 HMOs have disease management for diabetes.

These combined strategies enable better identification, outreach and ambulatory care for individuals with asthma and diabetes. Multiple strategies appear to be effective in improving quality of care.

Data suggest performance improvement opportunities may exist in several areas, for example, dental services, provision of Pap tests and screening mammography. In addition, steps may be necessary to re-energize improvement efforts in areas where improvement appears stalled.

Strategic options

These findings suggest several strategy options for further quality performance improvement program-wide. They include:

- Broaden the Care Analysis Project to include additional topics.
- Increase new enrollee participation in the NEHNA survey. This is being implemented as part of BadgerCare Plus).
- Move Monitoring Measures where performance has not improved or are below expectations to Targeted Performance Improvement Measure status. This has been done with Pap test and mammography indicators.
- Increase the number of topics included in the performance improvement goal-setting system. For 2007-2008, the Pap test and Mammography indicators have been added to goal-setting and the diabetes care indicators have been dropped.
- Consider additional HMO quality improvement performance incentives (P4P). This is being implemented as part of BadgerCare Plus.
- Consider options to increase the number and effectiveness of HMO performance improvement projects.
- Implement member-centric healthy living incentives. This is being implemented with BadgerCare Plus.

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